Vanderbilt Health DNA: Discoveries in Action
Season 2, Episode 5
Throw Out the Textbook: Trust and health amid misinformation in the COVID age

Dr. Laveil Allen: If there is a chest X-ray, usually the lungs are black. If a patient has COVID though, the lungs are white, meaning that air is not being respirated into the lungs as it should be. So COVID has the ability to take lungs of a 20-year-old and makes their lungs look like a 70, 80-year-old smoker.

Shon Dwyer: I really feel like it was relentless and it was in the moment, and it was people we were documenting as we were going and we were iterating as we were going. And I think people were scared at the same time, right? I mean, this was a scary thing for providers when we didn't know what we were dealing with.

Dr. Kimryn Rathmell: I think people were scared and I think people were looking for a direction, but I think people really wanted to do the right thing and be a part of the solution because they saw what was happening. In the early days, we would pull up these charts and you would see the red dots that were lighting up across China, and then Italy, and then Seattle and little dots here in Nashville, right? And you weren't sure what was going to come, but every time we called on people, people just rose to the occasions.

Clark Buckner: Let's meet the people you just heard from. They and colleagues here in Nashville and peers around the world made sure that we had a place to go if we needed medical care while the pandemic rage.

Shon Dwyer: Hi, I'm Shon Dwyer. I'm the president of Vanderbilt University Adult Hospital.

Dr. Kimryn Rathmell: My name is Kimryn Rathmell and I'm the chair of the Department of Medicine here at Vanderbilt University Medical Center and the physician-in-chief of Vanderbilt Hospital.

Shon Dwyer: I came here on March 2nd and that was my first day of work. That night, there was the tornado. I woke up and was texting. Thank goodness I had phone numbers in my phone of some of my people. And I came in in the middle of the night to the Command Center for that because our supply chain, one of our warehouses, had been hit by the tornado. So I was trial by fire from that minute because that was the same week that we had our first case of COVID in Tennessee. We started the Command Center. It never stopped. And my family would be, "How are you doing? Oh my goodness, how can you do this? There, you're brand new." And really, I said it's a good thing I know how to run a hospital. And really, because I think had I come and this would have been something completely new or a very large change in role for me, I think it would have been extremely, extremely difficult.

It's really difficult when you don't know the players because how you actually get things done is through other people and relationship-building. And so, for me, that was the biggest thing I had to do quickly

was to get an understanding of the people and how they functioned and who needed what for me to be successful. So that was really my biggest challenge in that. Where to put patients and how to do that and all of that, that's something I've done for many, many years, but COVID, of course, threw a lot of wrenches in that. But when you have a good team, you can get through anything and I think I learned very quickly. I had really good teams.

Dr. Kimryn Rathmell: I started January 1st as interim chair. I was just getting going and figuring out who was who and how this job works when this happened two months in. I've told a lot of people that I think actually there was a lot of benefit in that where I could learn how things worked very, very fast. There wasn't any choice. You had to learn fast. You had to get names down quickly and learn who could do what in a timeframe that was so compressed. Probably now a year and a half in, I probably would still be learning some of these things because they would have been not the pressure that they were, but instead by June, I knew a year's worth of material. So that's a benefit, the way that people were working so much in one direction. There were no challenges. Everyone's ideas were good. And even though mine were sometimes naive, they were still good. So yes, it was trial by fire. It was drinking from a fire hose, but I think this job would have been that regardless.

Dr. Laveil Allen: So hello, my name is Dr. Laveil Allen. I am the chief of the Emergency Radiology section here at Vanderbilt University Medical Center. As a radiologist, as it relates to what I see in the severity of disease in this pandemic and young people, it's been astonishing to see its impact. It's a first, right? I mean, for me, it's a first as a physician. And then, honestly, we test all throughout our medical careers so that we have seen it before, so it's not a first. But in this instance, for me, everything that I saw in early March, it was new to me.

At some point, I realized that I entered a very noble, noble profession, right? I mean, I wanted to be a physician. I wanted to take care of people. I want to do all these things. But in my mind, through this pandemic, I have come to see that physicians, nurses, nurse practitioners, all healthcare professionals, they're very akin to firemen, policemen because when everything was burning in March, then me as a physician, the only thing I had... I didn't have a gun to fight the perpetrator. I didn't have even an ax or oxygen mask like firemen did. All I had was a mask. It was just a regular hospital mask that I'm coming in into almost battle-torn territory in trying to fight the best I could.

I would imagine when you first go to war, you're seeing a layout that you've never seen before, right? In Vietnam, you're going into a jungle, right? You don't know what's really to be expected. In Saudi Arabia, they were going into sand. Well, for me, the environment that I was seeing was instead of being able to freely access a hospital, which I've done since my medical career started, I now have to walk through a temperature probe that is pointed directly at my head, right? And I'm thinking to myself, "Please, Jesus, don't let me have a temp," right? Not only for the patients, but for me and my family at home, because that means that me coming to work has now exposed my wife and child to COVID. So that's the first thing. When you're walking in, it's completely new.

Clark Buckner: You're listening to season two of Vanderbilt Health DNA: Discoveries in Action. I'm your host, Clark Buckner. The reasoning behind the show is quite simple, the path to better health lies in our DNA. Discoveries in Action is about the big ideas of breakthroughs happening right here in Nashville, Tennessee from Vanderbilt Health. Our drive to discover, care, learn, and share is in our DNA. It defines who we are just as your DNA defines you. That light-tapping sound, that's the echo of researchers drafting tens and tens and tens of thousands of studies about COVID-19, and the cascade is unrelenting. It's reframing much of what we thought we knew.

Dr. Kimryn Rathmell: I'll take that from a physician perspective and how we think about what a new disease means to the practice of medicine. That doesn't happen for us too often, that the textbook, it's rewritten and we have something that's new and dramatic that affects many, many of us, but COVID definitely did that. I think we're learning and we've been learning fast over the last year about how this disease is a lot more than pneumonia.

I remember standing up in front of the department as we were really just getting into this and saying, "This is our disease. We do pneumonia, Department of Medicine." But COVID and its aftermath is hematology. It's effects on the kidney, it's effects on the brain, it's effects on probably our personalities sometimes. It can do a lot of different things. And so, we're learning about that. So one of the things that we're doing is putting up a clinic that takes care of patients in the long-term afterwards and providing the services that will be necessary for those patients, but we don't know what that will look like a year from now or five years from now. We know what it is today. We're evaluating the patients as they come and putting together the groups of doctors that we need. But COVID, when we write the textbooks about it, will be an infectious disease with a really large aftermath.

Shon Dwyer: You know, I think one of the things that Kimryn mentioned is about how we're learning and learning as a group, and one of the things I think that COVID taught us inside the walls of the hospital with our clinicians is how we need to learn together because it really takes a team to take care of these patients, especially when you don't really know what you're dealing with and you don't know what's going to work.

And one of the things that I think our teams did really well together was to stand up a COVID service line, where they met multidisciplinary every morning and went over what is the new learning, what is the best plan for this patient, how do we bring what we are learning to the bedside immediately, and what's happening in the trials that we're doing, what's happening in the new drugs that are being tried, and how are we applying those and consistently doing that. At one point, we had about 150 patients, so it was one of our biggest service lines in our hospital. And we thought this is the way to really run a service line. We figured out how to do that and how to really bring that learning right to the bedside very quickly. I think that's one of the things that, as we think about the challenges of the future, how do we do that and do that consistently?

Dr. Kimryn Rathmell: I don't think anyone can say it enough how much people came together, we're on the same page, and really did epitomize that learning healthcare system, that we're here to figure this out every day and take in whatever piece of information we can and assimilate it and make a new decision, and tomorrow's a new day and we're going to do it, maybe just a tweak different and it'll be better until we've got it. And a few months in, we were pretty well-oiled machine in how we managed COVID.

One of the really interesting things was how many different groups were involved. For sure, we were standing up a service line, and so it was doctors and nurses and the people you expect, but there were people behind the scenes as well. One example is we have a division of epidemiology in the Department of Medicine and we're talking with them and they were saying, "Well, I'm not really sure what we can do, but we are really good at reviewing data and putting it into very concise information bullets." And so, they offered to do that. And then weekly, we'd put together all of the data that was coming out in all of the manuscripts and abstracts and publications.

And we felt, I'm sure we were the most informed of any group around the country because we had this resource that was being fed right to us that was accurate, detailed, reviewed, and immediate even though the data would be different next week and we would have a new report out from them. And so, this is a group of scientists who don't engage directly with the hospital, and yet we're influencing everything that we did every day in the hospital.

Clark Buckner: If you're like me, working and living through a pandemic has made me question who and what I trust. Our brains are making constant decisions about whether the information being presented or situation are trustworthy and safe. It's exhausting. And as you heard from Dr. Consuelo Wilkins in the previous episode, being trustworthy is paramount. But what does it mean to be a medical expert in an era characterized by misinformation and feelings over facts?

Dr. Laveil Allen: I would say, for me, is that it's made me very aware of my ability to build trust within my community as a physician because of the schooling that I have done. I'll give it... That's the reason. People trust me. They trust me to know more than they do about the particular topic of health. I am a professional, I am an expert. So in some ways, prior to the pandemic, me, myself, within my community, I always shied away and I tried to, "Hey, I'm just like you. I'm still here, haven't gotten a big head. Or from the standpoint of me being different, I'm just like you." But I have been really forced through this pandemic to embrace the fact that, in some ways, I'm not, right? I may look like you, I may run in the same social circles, or we have the same kind of cultural identity, but as it relates to my community, I have to be a stalwart of health, I have to be a stalwart of scientific truth, and I have to embrace that and be comfortable in that because the community needs me.

I always joke, and it's the truth, is that when I was in med school, when we were in med school, we don't study from a red book or a blue book. We just study from a textbook that gives us facts on how to help save lives.

Dr. Kimryn Rathmell: Trust is essential to be able to be effective in any of these roles or with any relationship-driven work. And I think when you're new in the role, I think you have to earn that trust. So another advantage of being trust into a situation so quickly is you have lots of opportunities to earn those points and show people that they could trust you. Similarly, I also had to learn my team and learn who I could trust and how and what capacity I could trust that individuals would deliver and in what ways. So you figure those things out.

I think the other thing to bring up here is a lot of other things were happening over this whole COVID period of time. We've clearly had big issues around racism and diversity in our institution, in our community, in our nation, and people learn that they're looking to us having to be able to trust us. And so, you have to be showing that you can deliver a plan for COVID, but similarly, you can show the way that people can best address other things that are going on in their lives. I don't know if that makes any sense at all. But I think because all of those things were happening, people developed different levels of trust with the department, with the people they're working with because so many things were happening at the same time and you had to learn to trust each other to be able to do anything.

Shon Dwyer: One of the things I would say about trust is can you reliably predict what someone is going to do, so mistrust or trust, right? If I can predict that you're going to be unpredictable, I don't trust you. If I can reliably predict how you are going to respond, that builds trust, right? And so, that's how I think about it. So can I understand where and how you're going to make decisions, as an example. And when I think about trust in this pandemic and in the social issues that we've had, if you think about it from that perspective, one of the things I think that surprised me actually was where people went for information. Who are you going to trust in a pandemic, right?

One of the things, for instance, I was thinking about is why are people trusting certain information streams that are known to be untrustworthy like Facebook? That was shocking to me. I mean, it seriously was. Because if you look at what people trust in healthcare, nursing is the number one trusted profession and has been in the Gallup polls for 19 years. I's over 80-some percent who trust nurses. So it was surprising to me. And not only nurses are trusted, but medicine and healthcare professionals in general are much more trusted. And why is that? Because we believe in science and we tend to share that with people and we're reliable in that way. So I think about it from that way. And from the external perspective, it's a bit of an interesting phenomena about why, during this pandemic, some of that happened.

But you also know that there is a history in our country around some of the other social, racial issues that healthcare profession wasn't trusted at a period of time. So I think it's way more complicated than we would like it to be, right? And there were a lot of intersections socially, politically, economically, all kinds of things happening at once. And so, I think what our organization really tried to do to say how do you build trust, you build trust by being predictable in what your principles are. You build trust by being transparent about what you know, what you don't know.

And that takes a lot of courage, I think, to be honest about some of those things, that when you don't have all the answers, you just say you don't have all the answers. So trust is a tricky thing. It's very personal, I think. It's person to person, it's person to organization, it's person to community, and you have to work on that and build it over time. It doesn't happen overnight.

Clark Buckner: Healthcare as a microcosm of the U.S. is crossing the Rubicon. There is no return to the pre-COVID normal. There is only forward through overdue conversations that will construct an environment that welcomes and works for those it previously excluded.

Dr. Laveil Allen: It's been interesting to see the cross-section of what I would say is we were in a pandemic as it relates to our health, but we were also in a social pandemic in some ways all occurring simultaneously. I'll tell you my own personal experience. So I am an African-American male. The listeners can't see me, but I am that proudly. I attended HBCU for college, Tennessee State University here in Nashville. I attended an HBCU for medical school, Meharry Medical College here in Nashville. So as it relates to health equity, it's always something that's in the forefront of my mind and has been.

I will tell you here at VUMC, a more specific reason of why I'm here, I've always been supported in that underlying notion of who it is that makes me me, which is trying to make sure that health equity is the word and brand of health equity is spread to as many people as possible, and having that support here at VUMC is huge. I do think that it's amazing to see how with the George Floyd protest that occurred, the NBA protests that occurred, all those things were happening simultaneously as we were fighting this health battle.

On the other side, I think synergistically, that's how we ended up where we are where now, when I look on MedTwitter, diversity, equity and inclusion, health equity, I mean, those aren't just buzzwords. I mean, those are trending topics almost every day. And I think the big thing is exposure, or I guess having those things be talked about, those are the first steps. Then, putting plans in place with people who have the ability to make sure their institutions emphasize those things, those are the next steps. But as with anything, the first step to solving a problem is recognizing that the problem is there, and I think that that occurred from the months of March through August of last year.

Clark Buckner: Even in the absence of a pillaging infectious disease, Dr. Allen and his ER colleagues see the health byproducts of the social pandemic that's been hitting the U.S. disregarded for many years. For our guests and their colleagues, the way forward is now lit by glimpses of what could be and what should be. The future is looking into the community to see where ills originate and working to be trustworthy ambassadors of health and equity.

Dr. Laveil Allen: As it relates to COVID, when you speak of why is COVID disproportionately impacting minority communities, well, minority communities are normally stacked a little bit closer on top of each other. As it relates to accessing care, there are definitely some things that can be improved there. When

you talk about the vaccine, that's the big thing right now, the vaccine, getting everyone vaccinated, why are vaccinations having it at a lower rate within minority communities? Well, a lot of those communities, people working two or three jobs, they may be taking care of kids, the access points are different as it relates to them taking care of their children and working those jobs.

The jobs initially may have told them, "Hey, listen, we need you here at work. There's not the time for you to go and get the vaccine." The great thing that I am seeing now, though, is you've got companies like Kroger, Target, where they're giving four hours off to their employees, paid time, for them to go and get vaccinated. Those things are huge. And in their encouragement, there is huge. With some of these incentives, I think that they can help decrease that gap of vaccination disproportionality.

The question that I wake up wanting to answer is getting more minorities involved in healthcare. I think that when you talk about trust, what is lacking right now in minority communities has just been, America as a whole, it's trust within the healthcare system. But within minority communities, if you have someone that looks like you, taking care of you, I think that that could bode very, very well for the trust that you have in the care that you're being provided. So the question for me is how do you do that? And the things and ideas that I have, one idea that I'm currently pursuing is something called Big Doctor, Little Doctor. With that program, it's something very similar to big brother, little brother or big sister, little sister in which we create a longitudinal mentorship. It may not increase physicians, but we increase minorities and healthcare in and of itself.

Shon Dwyer: During this pandemic, one of the things that really became crystal clear to everybody, I think, is the disparity issues. It was so front and center. So I think I would say how we measure progress is around disparities over time and do we start to address the issues that cause the disparities. Because in many ways, healthcare perpetuates those, but also so many things in our communities and how we handle social determinants of health, et cetera, how we think about public health, which people, we have neglected in the United States for many, many years. So I would say backing that train way up about how are we thinking and acting about public health, where are we putting our resources, and have we made a dent in the disparities in this country.

Dr. Kimryn Rathmell: I was thinking about if we could make progress as well. We were talking about trust before, trust in science and in medicine and in healthcare. I think that COVID has helped that as we see now with vaccine hesitancy and things. There are still long ways to go, so I would like to see us using this experience to make not just incremental, but really major progress in how people view science and health.

I think the other thing, and this resonates with a lot of the activities of Vanderbilt right now and also what Shon just said about overcoming disparities is how we serve and improve the health of the community, and that's beyond Nashville. But to everywhere that for us, for Vanderbilt serves, we're in a region of the country that has long been marked by the highest rates of cancer, heart disease, diabetes,

obesity, addiction, and I would love to be a part of changing that and we're well positioned to that. So that would also be really incredible progress, but very similar.

Shon Dwyer: I think one of the things that came out of the pandemic was that we're closer to the community than we've been before.

Dr. Laveil Allen: So I think that acknowledgement matters, right, and in that, pronouns matter. Seeing individuals that look like you, doing what it is that you aspire to do, that matters. And so, if you ask me, "Hey, what does diversity look like," it looks like the community that I care for. It's women, men, Black, white, Asian, Hispanic, all of these different things that make us America, that's melting pot, this smorgasbord of different cultures, identities. I think that as it relates to healthcare providers, we've got to gravitate towards that a little bit more. Because the old adage when you... Sometimes you'd think about healthcare and more specifically physicians, people will talk about an old, bald white man, right? That's the thing that they use. But I'll tell you here at Vanderbilt and what I've seen, that narrative is shifting and it's becoming, in some ways, obsolete, maybe not rapidly enough.

But for me, I'm assistant program director within the radiology residency program, and we have a huge initiative, huge push to make sure that we identify individuals, diverse candidates that can come in and provide that diversity that we need to take care of people and look in taking care of them the same way they look when they're walking into our offices. I think it's important though that we don't sacrifice quality. Radiologic images are black, white, and gray scale tip. That's all I see. I don't see any skin surface, none of those things. Now, sometimes based on muscle tone, I can tell if you're working out or not, right, but outside of that, no. I mean, it's kind of de-identified, right? And for me, I really love radiology because of that fact.

Not to knock any other specialty, but I remember when I was doing my intern year, so many times you would start off, "Patient is a 36-year-old African-American male, Caucasian female," and that always struck me as a little weird. I get that sometimes different disease processes affect different communities, but I don't know that you have to lead off with that. And thankfully, it's actually going to push now to eliminate some of that. I think maybe now on the wars here at Vandy, they no longer use those identifying constructs. But yes, radiology is awesome. And that for me, I'm looking at you as a patient. Now, I can also sometimes tell based on anatomy whether it's male or female, but ultimately, it's a rewarding profession for me because it's really aligned with my belief system and values.

Clark Buckner: If you like these conversations, then check out the previous episode. Y'all means all. On our next episode, we'll sit down with a radiation oncologist, a cardiologist, and a data scientist to explore clinical trials of the future. To learn more about the show, check out episode extras and find more information about Vanderbilt Health and today's experts. Visit listendna.com. You can also find us on Twitter at VUMC_Insights and on all of your favorite platforms at Vanderbilt Health. And of course, don't forget to follow, rate, and review this show anywhere and everywhere you get your podcasts like

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